Facial Consent Form

I hereby authorize my practitioner to perform a Facial Treatment.

The following points have been discussed with me:

- Our medical spa facials are corrective procedures and not designed only for pampering. We treat the face and those parts of the neck affected by skin disorders including acne, razor bumps, clogged pores, blackheads, dehydration, dead skin cell build-up, etc.
- The goal of a facial treatment as in any cosmetic procedure is improvement, not perfection. We recommend a facial for all skin types and all ages.
- For optimal results the use of daily at home skincare products prescribed by your provider is recommended.
- Extractions may be added to treatment to gently and safely remove blackheads, drain inflamed acne impactions, and release trapped ingrown hairs.
- If extractions are done wait 24 hours before applying acne and other active products, scrubs, astringents, lighteners, AHA/BHA, Retinol and/or other vitamin-A products.
- Facials could cause temporary redness and/or purging of the pores.
- You should let your provider know if you are pregnant, have asthma, and/or sensitive areas.

Facial Treatment Includes:

- Deep Cleansing
- Mild Exfoliation
- May or May Not Include Steam
- Massage of Face, Neck, Decollate, Shoulders, Arms, and Hands Mask
- Moisturizer
- SPF

ACKNOWLEDGMENT

Facial has been thoroughly explained to me. I realize that no promises or guarantees have been made. I understand that the treatment may be repeated several times to achieve complete satisfaction. I understand that this treatment is voluntary on my part. By signing this form, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. I understand that I can call or return to the office at any time with questions or concerns.

I consent to allow the medical personnel/licensed esthetician to perform a facial treatment.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, _____, HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE.

_____

Patient Signature & Date